A Surgeon and a Soldier— An Interview with Booker King, MD, FACS

George Dawson, MD
Harlem, New York

Periodically, for the past two years, the editorial staff of the *Journal of the National Association* has attempted to—for history's sake—highlight physicians of color.

In this vein, and in light of the current hostile activities in the Persian Gulf, we felt it important we our bring readers, in this issue, the background and views of an African-American physician/soldier who served in the Iraqi theater of operations during the initial combat. Notwithstanding the current political machinations regarding the legitimacy of the conflict, his story is both insightful and inspiring because, in the end, it is soldiers and their families who bear the psychological and physical burden of armed conflicts.

Finally, because of the history of privation that persons of African ancestry have had to endure in these lands, we feel it important that we, in these times, tell our story, on our terms. And Dr. Booker's story is one we feel truly proud to present.

This interview was conducted by George Dawson, MD. He serves as editor of the Art in Medicine, History and Health Tidbit sections of the *Journal of the National Medical Association*.

Key words: Brooklyn ■ military ■ combat surgeon ■ mobile Army support hospital (MASH) ■ Iraq

 Send correspondence and reprint requests for *J Natl Med Assoc*. 2005;97:644–647 to: 1012 Tenth St. NW, Washington, DC 20001; e-mail: gdawson@earthlink.net

Dr. King was awarded his Doctorate of Medicine in 1994. He was commissioned a captain in the U.S. Army Reserves during his surgical residency training in 1995. After completing his surgical training in 1999, he was assigned to the 28th Combat Support Hospital in South Carolina.

DAWSON: When were you born?

KING: I was born in 1969 in Brooklyn, NY.

DAWSON: Are you married?

KING: I have been married for 10 years and have five children.

DAWSON: Are you a religious man at all? If so, how does it affect your life as a person and as a physician?

KING: Religion is the central part of my life both as a physician and as a person. Residency training focuses on the clinical and technical skills needed to take care of patients. My ability to be compassionate and empathetic is largely derived from my religious and moral training.

DAWSON: Where did you go to school, beginning with high school?

KING: I went to Clara Barton High School for Health Professions in Brooklyn, NY. Subsequently, I attended the Sophie Davis School of Biomedical Education as an undergraduate. This is a seven-year BS/MD program at City College of New York in Harlem, designed to increase the number of minorities in medicine. The focus also was to expose potential physicians to the maintenance of healthcare in underserved communities. My final two years at the Sophie Davis program were spent at one of seven affiliated medical schools in New York to complete the clinical clerkships. I spent my two years at New York University School of Medicine. I then completed my surgery residency at SUNY Buffalo (1994–1999). I chose Buffalo because of the African-American surgeons there who could serve as my mentors.

DAWSON: When did you take your board certification exam, and what were some of your experiences during the board exams?

KING: I completed my board certification in 2001. I was surprised how confident I was during the oral examination. I guess all those times I had to present in front of highly critical attending staffs during morning report paid off. As an added note, I have just recently been inducted as a fellow of the prestigious American College of Surgeons.

DAWSON: Do you have any memories or experiences that shaped your decision in becoming a physician, in becoming a surgeon?

KING: One memory I have was as a medical student beginning my clinical clerkships at NYU. I was on call on my medicine rotation when a surgery resident asked me to help transport a trauma patient to the OR. He was so grateful that he asked me to scrub into the case. The next day I had to explain my whereabouts to the chief medical resident. Obviously, he was not happy to hear my explanation but applauded my efforts to expose myself to surgery.

DAWSON: Do you have any family members in healthcare? If so, doing what?

KING: My mother-in-law is a dialysis nurse in Arizona. She provided a lot of support to me and my family during my training in Buffalo.

DAWSON: What is your most important personal asset as a surgeon?

KING: The most important personal asset I have as a surgeon is something that is not usually associated with the profession of surgery—compassion. It is the sole attribute that drives us to devote all our mental ability and technical skills to patient care. Compassion is an essential part of every physician's practice. As a wise surgeon once told me, "to be successful in this business you have to develop the three Hs—the head, the hands and, above all, the heart."

DAWSON: What is the most important instrument and/or item to facilitate your practice as a surgeon?

KING: All instruments are important, but an old Army surgeon told me that you can perform almost any operation in the field with a scalpel, tissue forceps, a needle holder, the right suture, of course, and a good pair of scissors.

DAWSON: Since starting your military career as a physician, what has impressed you the most about the military?

KING: I have been most impressed by the versatility of military surgeons. A military surgeon can be performing a complex surgery at a large military medical center one day and performing lifesaving surgery on a wounded soldier in a tent in the middle of the desert the next day. Basic soldier survival skills become just as important as surgical skills in these austere environments.

DAWSON: What has been your most interesting duty tour station, outside of combat zones?

KING: My Bosnia-Herzegovina deployment was very interesting (March to October 2001). I had a chance to interact with physicians from other nations. Most interesting were my interactions with the Russian surgeons, who made several presentations about medical care during their war with Afghanistan in the 1980s.

DAWSON: How about Iraq—what can you share about that experience?

KING: I was deployed from the 14th of February to the 15th of May 2003. We were deployed to Kuwait initially and were situated 13 miles south of the Iraq

border. On March 20, 2003, the unit, consisting of a convoy of over 30 vehicles, traveled from Kuwait to a small area near Najaf, Iraq. The trip took 78 hours, and we bypassed some of the fiercest fighting of the earlier war. The mobile hospital was set up during a sand storm. And, we went on to perform over 100 surgical cases in three weeks. The unit was operational until mid-April 2003. We were redeployed home, in groups, from mid-May to mid-June.

The weather was bearable when we arrived in Kuwait in February; however, the nights were cold. Sand storms were frequent (an average of one per week). In fact, the sand storm that occurred while we set up the hospital in Iraq was the worst storm Iraq had experienced in 20 years. From April to May, it was extremely hot during the day, reaching temperatures of 110–130ºF. Needless to say, not many manual tasks could be accomplished during daylight hours. Then, there were the local vermin—things like sand flies, scorpions, spiders and reptiles of all types—kept us focused on our immediate environment.

The 212th MASH (last MASH in the Army) is one of the best field hospitals in the Army. We functioned as a true combat unit, dividing all of the manual as well as administrative tasks among all members of the unit. There are very few medical units in which you can get medical officers and nurses to set up TEMPER tents, move heavy equipment, load trucks and even drive military vehicles through an active combat zone. I worked alongside four great surgeons. We insured that the work was evenly divided. The nursing and ancillary staff was superb as well.

DAWSON: Excluding the heat and vermin as they were mentioned earlier, how were your living arrangements?

KING: I was told early in my military career, as a medical officer, never to complain about living conditions in the field. As bad as conditions were for us, we were in heaven compared to the conditions the combat units endured on the frontline. But it was no Sunday walk in the park for us. We lived in tents and slept on cots. You were in arm's reach of the person beside you. You lived out of your duffle bag and Ruck sack. We had two hot meals a day and a five-minute shower twice a week, if we were lucky. People often decorated their living space with cards, photos and letters from home to keep up the morale.

DAWSON: What was your work schedule like?

KING: We devised a call schedule, but when the casualties started to pour into the hospital, call schedules were useless. Many of the patients came at night when the coalition forces performed the majority of their maneuvers. It was not unusual to have 10–20 patients arrive at the hospital at once. The unspoken rule was that everyone was available to help when needed.

DAWSON: What kind of dangers were you in on a day-to-day basis?

KING: Field hospitals do not have heavy-armored vehicles or tanks. We rely on combat units we travel with for protection. There are always the dangers of enemy capture, attack with artillery or rocket propelled grenades, and improvised explosive devices on the roadside and accidents as the result of traveling in a harsh terrain. During the early phase of this conflict, threat of biological or chemical weapons was a concern as well.

DAWSON: Did you have any unusual combat or noncombat cases?

KING: I don't think many medical units suspected that there would be so many gynecological issues. The MASH unit was faced with every gynecological problem from ectopic pregnancy to ruptured ovarian cyst. Fortunately, many of these soldiers were evacuated to the rear for definitive care. Gynecology on the battlefield first became an issue in Desert Storm. Female warriors made a greater percentage of the fighting force in Operation Iraqi Freedom (OIF), and the numbers are growing with each deployment rotation.

External fixation of long-bone fractures is certainly a common procedure during wartime. The majority of injuries are orthopedic. It is unusual, however, to see general surgeons performing these procedures. Orthopedic injuries were so plentiful that we all participated in these treatments. Some limited training for all the staff of basic management of traumatic orthopedic injuries is essential.

DAWSON: Do you offer any advice for other doctors in military operations?

KING: The mission of the war has changed dramatically. It began with the mission to topple Saddam's regime but has converted to a mission of counter-insurgency. The medical mission must adjust with the war mission. Surgeons are now seeing more devastating injuries to soldiers as a result of improvised explosive devices and suicide bomb attacks. The enemy is becoming more sophisticated with each attack. Remember above all, personal safety and security of the unit is paramount.

DAWSON: Do you offer any advice to young doctors and students?

KING: The military is an excellent way to serve your country. I think all doctors should explore this option. You need to research all aspects of the military before making this a career decision. There are so many opportunities in the military. But the military definitely is not for everyone.

DAWSON: How did you keep up with CME?

KING: We lectured to each other and CME was provided through the Landstahl Region Medical Center in Germany. I did several lectures on the management of burn injury and thoracoabdominal trauma. These lectures helped us prepare for some of the cases we saw in Iraq.

DAWSON: Any regrets in career choices so far?

KING: No regrets. It has been a privilege and an honor to serve my country in this capacity. Providing surgical care in a war environment is the greatest mission and task for a military surgeon. Many surgeons have not had the opportunity to perform in a war zone.

DAWSON: Personally, what, in your opinion, was the very worst aspect of your deployment?

KING: The worst aspect of deployments such as these is separation from family and friends. Much research has been dedicated to assessing "combat stress" and the psychological effects of war on the soldier. There has been little research on the effects of deployment in a war zone on spouses or other family members. The stress on family members can be as great and, in some cases, greater than that of the soldier. It was difficult for my family when I was deployed to Iraq. The ability to send electronic mail and an occasional letter to family members provided great boosts to morale.

DAWSON: Any professional regrets?

KING: No real regrets related to my professional career, but I will like to pursue an academic position at one the Army's medical centers in the not too distant future.

DAWSON: Any advice for NMA?

KING: I thank the NMA for granting me this opportunity to represent the surgeons who have deployed to Iraq, Afghanistan and Kuwait. We are on the frontlines often embedded with combat units, providing care to our soldiers and marines. It is important to have the support and acknowledgement from medical organizations, such as the NMA. Many advances in the delivery of medical care on the battlefield will occur during OIF. As in the past, these lessons will lead to advances in civilian trauma care.

DAWSON: Thank you for your time and effort.

KING: You are more than welcome. ■

We Welcome Your Comments

The *Journal of the National Medical Association* welcomes your Letters to the Editor about articles that appear in the *JNMA* or issues relevant to minority healthcare. Address correspondence to ktaylor@nmanet.org.